

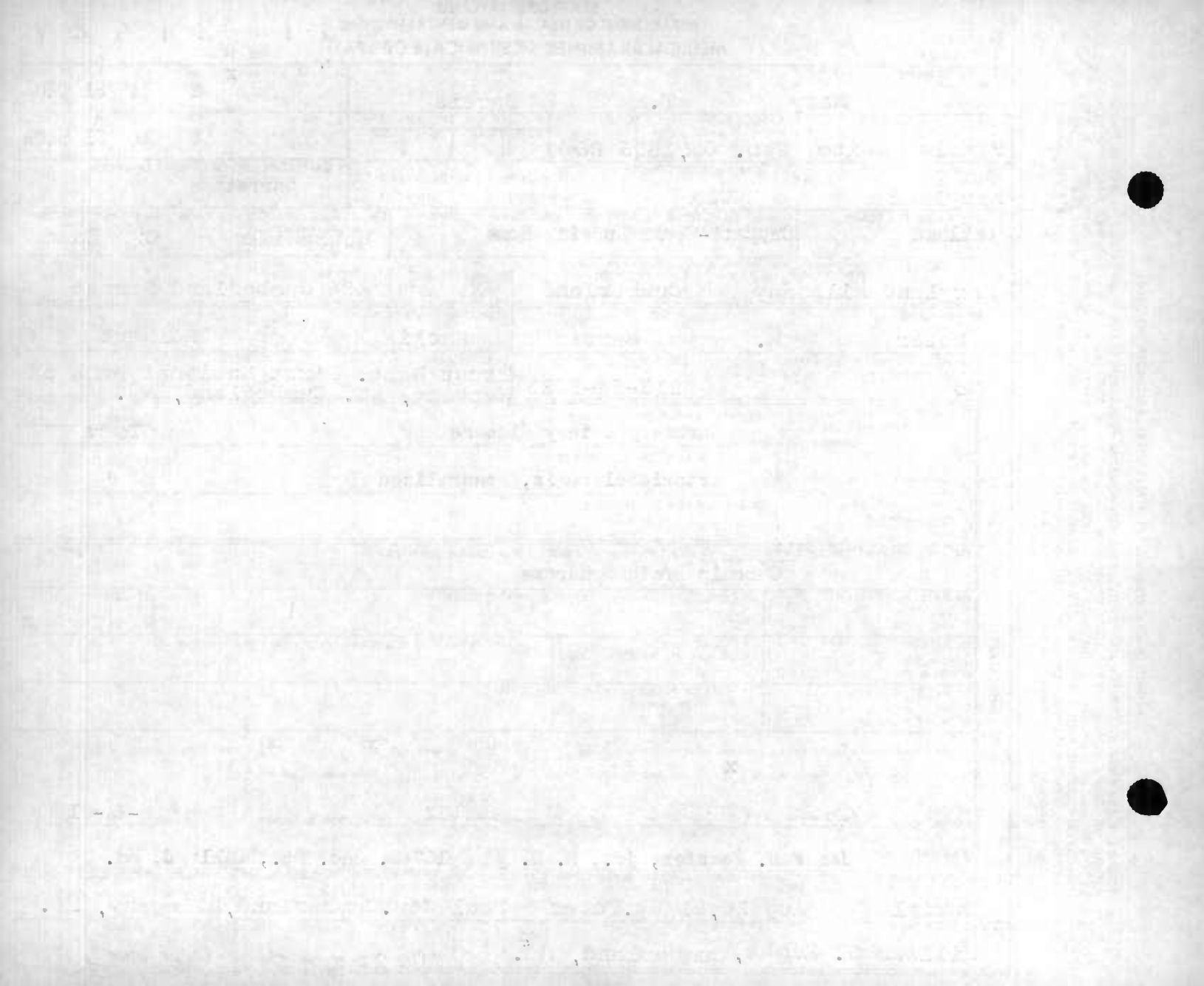
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21429							
1. FOR STATE REGISTRAR		FIRST MIDDLE LAST								2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		Mary T. Bareis								8		24		19 81		920A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Female		White		Feb. 05, 1895		86 YRS.						8		24		19 81 940A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA										Garrett MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Oakland		Cuppert-Weeks Nursing Home						Housewife				Own Home					
13a. STATE										13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Maryland										Allegany		YES		434 Cumberland Street			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME							
Peter R. Bareis										Amelia Reihert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No										213-64-9623		Trust Dept. First National Bank of Western, Md. Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:										Years							
IMMEDIATE CAUSE (a) Coronary artery disease																	
4149 Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last.										Arteriosclerosis, generalized							
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
Chronic Brain Syndrome																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
								CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an										Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion	
death resulted from										Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>	
										Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE										TITLE (SPECIFY)		DATE					
James H. Feaster, jr., M. D.										DEPUTY		8-24-81					
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS							
James H. Feaster, jr., M. D.										107 S. 2nd. St., Oakland, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				Aug 26, 81		St. Peter & Paul Cem.				Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William G. Kight, ADDRESS										AUG 28 1981		[Signature]					
William G. Kight, Cumberland, Md.																	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 4 3 0	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				REG. NO.	
1a. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
Earl Bittinger				8 16 81	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		MONTH DAY YEAR	
				2 8 1913	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		USA		68 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Oakland		Cuppert-Weeks Nursing Home		Garrett County, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
---		---			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Garrett		Grantsville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Charles Bittinger		Sarah Hoover		13e. STREET ADDRESS	
				Route 2	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		---		212-88-7126 John Bittinger, Main St., Grantsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cerebral thrombosis				hrs	
4292 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular insufficiency				yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis CV Dis.				yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 80 to Aug 19 81, that (I) (we) last saw the deceased alive on 8-14-81, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
B.L. Grant, M.D.				8-16-81.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
B.L. Grant, M.D.				Oakland, Md. 21550	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		8-17-1981		Westview Mem. Park	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
A. Susan Newman		Grantsville, Md.		AUG 21 1981	

BP

1940-1941

Supplies - 1st 1/2 year

1941-1942

1942-1943

1943-1944

1944-1945

1945-1946

1946-1947

1947-1948

1948-1949

1949-1950

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an entry made on this certificate.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 4 3 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Geraldine Loretta BOBO			2a. DATE OF DEATH MONTH DAY YEAR August 22, 1981		2b. HOUR 11:40P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 17, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett Co., MD		
10. CITY OR TOWN OF DEATH Oakland,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business	12b. KIND OF BUSINESS OR INDUSTRY Resturant	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Garrett	13c. CITY OR TOWN Oakland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Cramer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lela Whitmyer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-22-3298	17. INFORMANT G. Robert Bobo same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 3030 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Weeks</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>subarachnoid hemorrhage</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 19 69</u> to <u>22 Aug 81</u> , that (I) (we) last saw the deceased alive on <u>27 Aug 19 81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. E. Mance</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>24 Aug 81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. E. Mance		22e. ADDRESS Oakland, Md. 21550			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/81	23c. NAME OF CEMETERY OR CREMATORY Garr. Memroial		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Md.
24. FUNERAL DIRECTOR NAME Robert M. Durst		ADDRESS Oakland, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 26 1981	

MEDICAL CERTIFICATION

29

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR


REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Daisy		MIDDLE Ellen		LAST Cogley		2a. DATE OF DEATH		MONTH Aug.		DAY 1		YEAR 1981		2b. HOUR 8 ²⁵ AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH		MONTH 5		DAY 13		YEAR 1985		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) (MD.) Oakland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD											
10. CITY OR TOWN OF DEATH Oakland.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppett-Weeks Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Maryland.		13b. COUNTY Garrett		13c. CITY OR TOWN Oakland.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 420 8 th Street									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST Harrison		MIDDLE -----		LAST Whorl		FIRST Eva		MIDDLE Ann		LAST Sterling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						16b. SOCIAL SECURITY NO. 213-74-6875		17. INFORMANT Harold Gower, Oakland, Md. 21550									

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>	<u>Yrs.</u>
	DUE TO, OR AS A CONSEQUENCE OF	
	(b) <u>Myocardial Insufficiency.</u>	<u>Yrs</u>
	DUE TO, OR AS A CONSEQUENCE OF	
	(c) <u>Arteriosclerotic CV Disease</u>	<u>Yrs</u>

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION	PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic bronchitis - emphysema.</i>			
	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) XXXXXX <i>July 30</i> attended the deceased from <i>Apr.</i> 19 <i>64</i> , to <i>August 21</i> 19 <i>81</i> , that (I) XX lost saw the deceased alive on <i>July 30</i> 19 <i>64</i> and that in (my) XX opinion death occurred on the date and hour and from the causes stated above. (I) may did not see view the body after death.				
22b. SIGNATURE <i>B. L. Grant</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-1-81</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. B. L. Grant, MD</i>		22e. ADDRESS <i>Third St., Oakland, Md. 21550</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 8/2/81	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION CITY OR TOWN Oakland, COUNTY Barrett, STATE Maryland
24. FUNERAL DIRECTOR NAME Bradley A. Stewart		ADDRESS Oakland, Maryland 21550	25. DATE RECEIVED BY THE STRAITS 8/3/81
			26. REGISTRAR'S SIGNATURE 

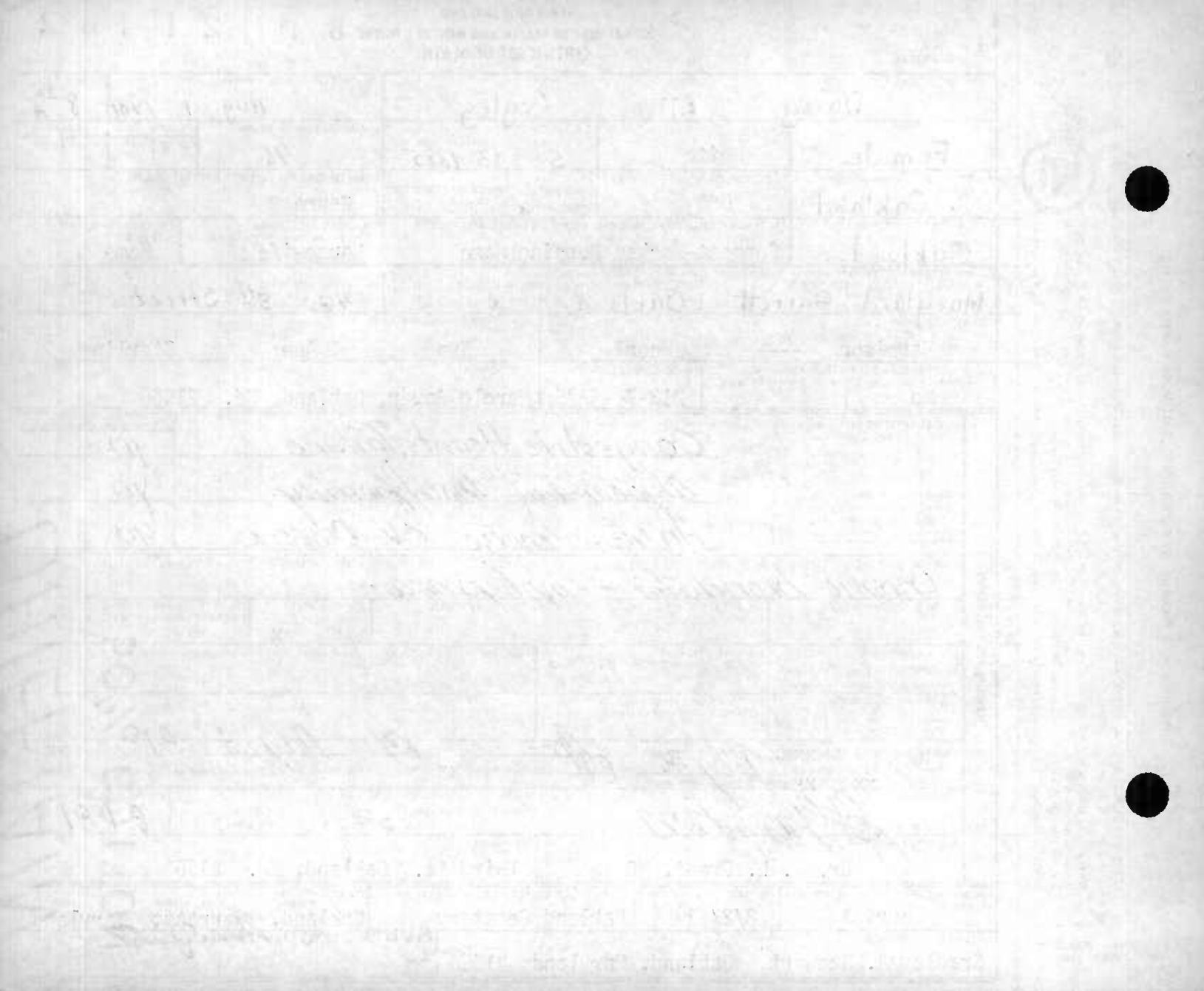
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled with the cause and death by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 7/77
(VR A 15 (4))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 4 3 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fannie Pearl CUPPETT				2a. DATE OF DEATH MONTH DAY YEAR 08 08 81		2b. HOUR 1028 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 14 1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE W. Va.		13b. COUNTY Preston		13c. CITY OR TOWN Terra Alta		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Kisner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stockett		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 235-22-7013	
17. INFORMANT Robert F. Cuppett		18. ADDRESS 207 Richfield Lane Terra Alta, W. Va.					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cardiac Pacemaker, Hypothyroidism</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James Beecher MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/12/81		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kingwood Preston W. Va.	
24. FUNERAL DIRECTOR NAME <u>John K. Whitcomb</u>				ADDRESS Terra Alta W. Va.		25a. DATE REC'D. BY REGISTRAR AUG 17 1981	
				25b. REGISTRAR'S SIGNATURE <u>James Beecher</u>			

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) Rosa Daule DUMIRE					2a. DATE OF DEATH August 18, 1981		2b. HOUR 11:23				
3 SEX Female		4 RACE White		5. DATE OF BIRTH 3/12/1896		6. AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.					
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE W. Va.					13b. COUNTY Randolph		13c. CITY OR TOWN Norton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Markus B. Dillsworth					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Mareland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 233-96-0297		17. INFORMANT William A. Dumire			ADDRESS Norton, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Osteomyelitis of R hip & femur											
19a. DATE OF OPERATION 8/6/81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Osteomyelitis of R hip & femur			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/29 , 19 81 , to 8/18 , 19 81 , that (I) (we) last saw the deceased alive on 8/18 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Louis Rishel					DEGREE MD		22c. DATE SIGNED 8/19/81		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Rishel, M.D.					22e. ADDRESS 4th St. Oakland, Maryland 21550						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/21/81			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Thomas Tucker W. Va.		
24. FUNERAL DIRECTOR NAME Robert M. Durst					ADDRESS Oakland, Md.		25a. DATE REC'D. BY REGISTRAR AUG 61 1981		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

4401-2-2-02

11:22 August 1, 1941

White

Garrett

Garrett Co. Memorial Park

W. Va. Harpersburg

Harper

233-36-027 William A. Harper

Harper, W. Va.

Robert A. West

Harper, W. Va.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR'S COPY OF THIS CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harry Carey FETHER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 8 19 81		2b. HOUR 730 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-8-1936	6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County, MD.
10. CITY OR TOWN OF DEATH Lonaconing		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rural Rt. 1		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military	12b. KIND OF BUSINESS OR INDUSTRY Marine Corps
13a. STATE Ohio		13b. COUNTY Stark	13c. CITY OR TOWN Canton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1621 Shorb Ave., N.W., #3
14. FATHER'S NAME FIRST MIDDLE LAST Harley Fether		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Belle		16. SOCIAL SECURITY NO. 292-30-9402	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 292-30-9402		17. INFORMANT Edith E. Fether, Canton, Ohio 44703	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c) "					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus; Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		TITLE (SPECIFY) M.D. DEPUTY		DATE SIGNED 8-8-81	
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M.D. ADDRESS 107 S. 2nd. St., Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-12-1981	23c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Garrett, Md.	
24. FUNERAL DIRECTOR NAME <i>D. Lynn Duman</i> ADDRESS Grantsville, Md.		25a. DATE REC'D. BY REGISTRAR AUG 11 1981		25b. REGISTRAR'S SIGNATURE <i>James H. Feaster, Jr.</i>	

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0121 333 333

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 4 3 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Lulu Bell HARDESTY				2a. DATE OF DEATH MONTH DAY YEAR August 23, 1981				2b. HOUR P 1:40 M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 24, 1888		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.					
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppert-Weeks Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Md.				13b. COUNTY Garrett		13c. CITY OR TOWN Mt. Lake		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 109 'G' Street	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Jefferson Roy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Jane Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-74-6092		17 INFORMANT Mrs. A.D. Graham		ADDRESS 4300 Kaywood Dr. Mt. Ranier, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Insufficiency 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from April , 19 68 , to August , 19 81 , that (I) (we) lost saw the deceased alive on Aug. 19 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B.L. Grant M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/23/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.L. Grant, M.D.						22e. ADDRESS Third St. Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/26/81		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley		23d. LOCATION CITY OR TOWN COUNTY STATE (rural) Oakland Garr. Md.			
24 FUNERAL DIRECTOR NAME Robert M. Durst						24b. ADDRESS Oakland, Maryland		25. DATE REC'D. BY REGISTRAR AUG 26 1981			

BP _____

August 23, 1951

James E. Young, Jr.
Garrett

James E. Young, Jr.
Garrett

James E. Young, Jr.
Garrett

James E. Young, Jr.
Garrett

James E. Young, Jr.
Garrett

James E. Young, Jr.
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James E. Young, Jr.
Garrett

James E. Young, Jr.
Garrett

James E. Young, Jr.
Garrett

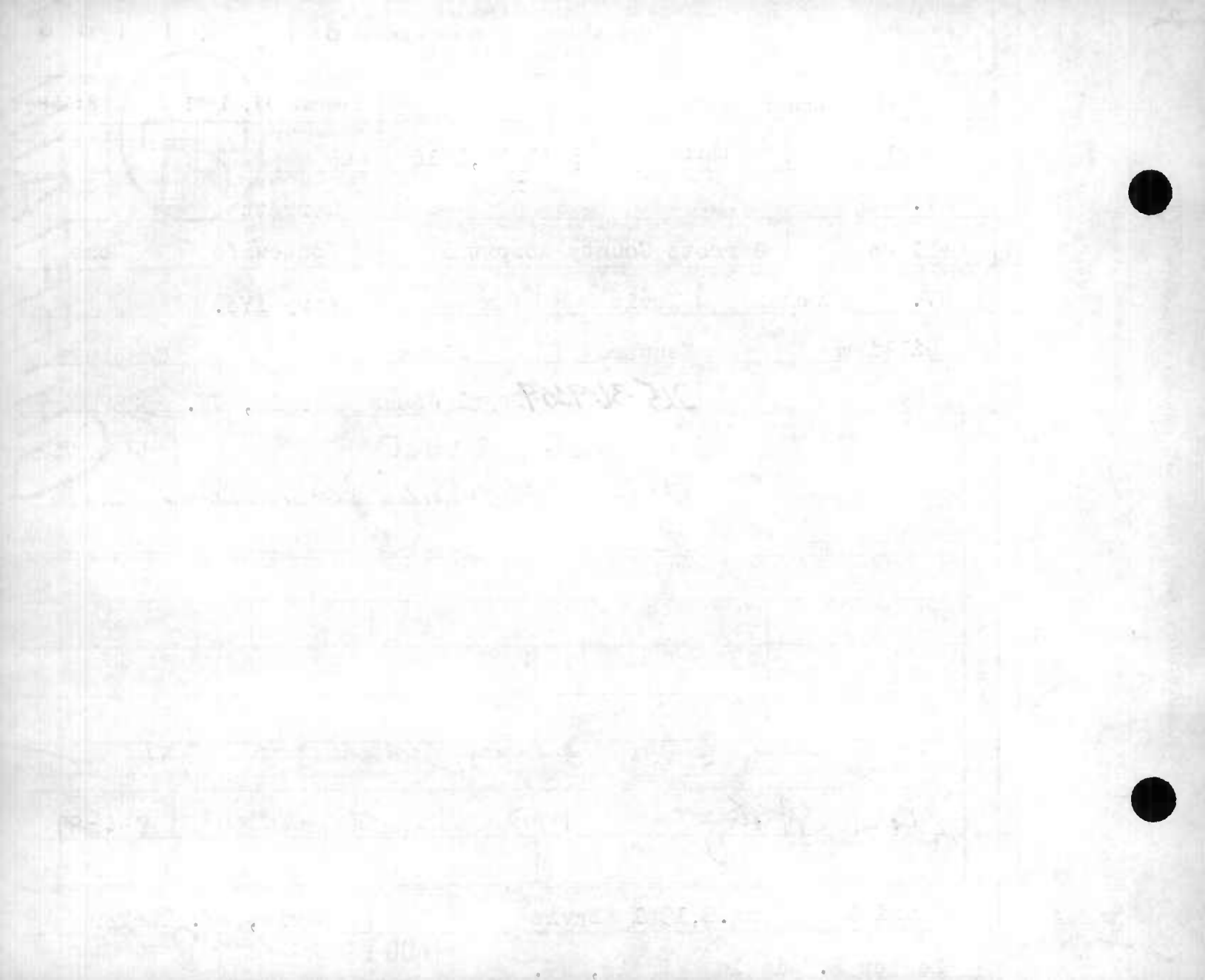
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 855-6655.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 4 3 8	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
Ruth Agnes JAMES				August 05, 1981	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		April 11, 1918	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
WV.		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Oakland		Garrett County Hospital		Housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
WV.		Tucker		Davis	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS	
William		Kennard		Flora Campbell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No		215-369159		Loyal James Davis, WV. 26260	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>				minutes	
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) <u>Chronic Obstructive Pulmonary Disease</u> Years	
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) (this hospital) attended the deceased from <u>January 8-5-81</u> to <u>8-5-81</u> that (1) (we) last saw the deceased alive on <u>8-5-81</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
23a. SIGNATURE <u>Lester R. Hinkle</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>8-6-81</u>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Aug. 8, 1981		Davis	
24. FUNERAL DIRECTOR NAME		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D BY REGISTRAR	
Lester R. Hinkle		Davis, WV. Tucker		AUG 12 1981	

BP



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must file a medical report.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 2 1 4 3 9	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Kathryn R. La Velle			2a. DATE OF DEATH MONTH DAY YEAR August 24, 1981		2b. HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett Co. MD
10. CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Cain			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brady			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 214 67 6361		17. INFORMANT ADDRESS Margaret Fair, 6 Mt. Pleasant St., Frostburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>prob stroke m/c</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>bad w/ argonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-24-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>[Signature]</i>		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/27/81		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Md.
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr. La Vale, Md.				25a. DATE REC'D. BY REGISTRAR SEP 1 1981		
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21440	
1- STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST MIDDLE LAST Mary Elizabeth LIPSCOMB										2b. DATE ESTIMATED MONTH DAY YEAR 8 9 81	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 12, 1892		6. AGE (IN YEARS) LAST BIRTHDAY 88 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 9 81		7d. HOUR 145A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Oakland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Cuppitt-Weeks Nursing Home				9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.										13b. COUNTY Garrett	
13c. CITY OR TOWN Oakland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Alder Street					
14. FATHER'S NAME FIRST MIDDLE LAST David ----- Lee					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Harvey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 235-78-2057				17. INFORMANT ADDRESS Mrs. Sylvia Liller, Rt. #3, Oakland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years "											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Emphysema											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>						TITLE (SPECIFY) DEPUTY			DATE SIGNED 8-9-81		
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M. D.						ADDRESS 107 S. 2nd. St., Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 8/12/81		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery				23d. LOCATION ST. CITY OR TOWN COUNTY STATE St. George, Tucker, West Va.	
24. FUNERAL DIRECTOR NAME Bradley A. Stewart						ADDRESS Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRAR AUG 17 1981			

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 4 4 1

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harvey Guy Loughry			2a. DATE OF DEATH MONTH DAY YEAR 8-24-81		2b. HOUR 1910 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-10-93	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett		
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner	12b. KIND OF BUSINESS OR INDUSTRY MD.	
13a. STATE WV	13b. COUNTY Preston	13c. CITY OR TOWN Terra Alta	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. # 2	
14. FATHER'S NAME FIRST MIDDLE LAST John Wesley Loughry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael Lipscomb		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 232-24-4227	17. INFORMANT ADDRESS Robert Clayton Loughry, Rt. # 2, Terra Alta, WV 26764		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCD (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James Beecham MD		DEGREE		22c. DATE SIGNED 8/24/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 105 Highland Ave. Terra Alta, WV 26764			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-27-81	23c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Terra Alta, Preston, WV 26764
24. FUNERAL DIRECTOR NAME John K. Whitehair		25. PREPARED BY NAME John K. Whitehair	

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Harvey

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5-1-43

White

Male

Arrest

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Arrest (e. Terminal Hospital)

Female

St. S

X

Robert

Arrest

Arrest

Arrest

John Arley

Robert Arley, St. S, 1000
Arrest

232-24-1027

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Arrest

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Arrest

8-27-81

Arrest

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Arrest

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Boulah Ruth NAYLOR			MONTH DAY YEAR 8 20 1981			415A		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Female	White	MONTH DAY YEAR 5/28/1892	YRS. 89	MONTHS DAYS	HOURS MIN	MONTH DAY YEAR 8 20 1981	420A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
W. Va.		USA				Garrett MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Oakland		Garrett Co. Mem. Hospital				Housewife		Own Home
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Md.			Garrett	Oakland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	24 E. Pennington Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Howard Michael			FIRST MIDDLE LAST Carrie Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			220-44-3781			Arthur E. Naylor Jr. Oakland, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4360 (b) Arteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fractured pelvis								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 230** 8 15 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell while walking to bathroom			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Residence		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 24 E. Pennington St. Oakland Garrett ,d.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>			TITLE (SPECIFY) M.D. DEPUTY			DATE SIGNED 8-20-1981		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
James H. Feaster, Jr., M. D.			107 S. 2nd. St., Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (S-E-C-Y)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			8/22/81		Oakland Cemetery		Oakland Garrett Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert M. Durst			AUG 21 1981			<i>Robert M. Durst</i>		

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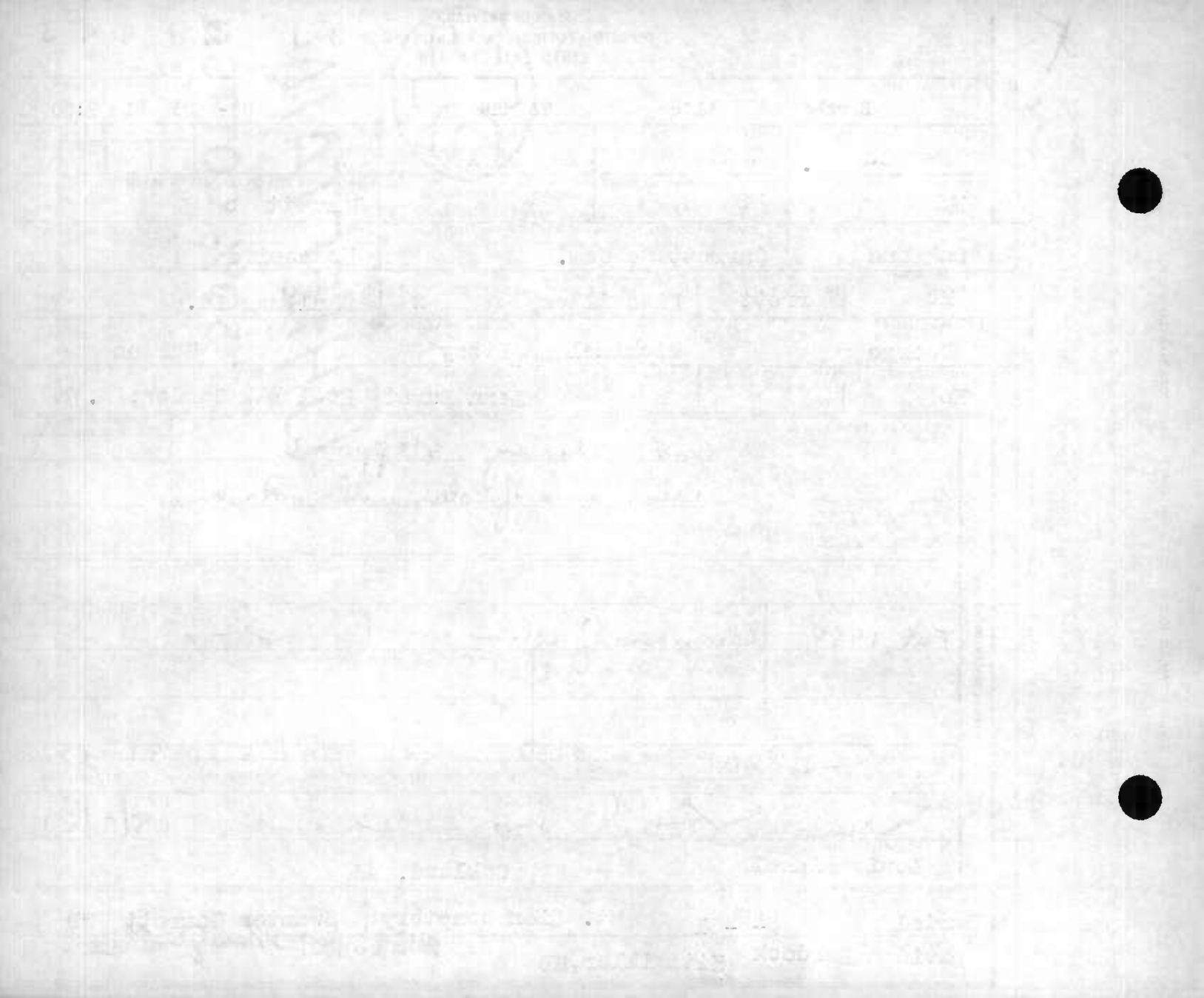
1518-pp-059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha Alice TASKER					2a. DATE OF DEATH MONTH DAY YEAR 08- 05 81					2b. HOUR 9:50 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 25 1901		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett Co MD				
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co Men.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Garrett 13c. CITY OR TOWN Kitzmiller					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Shallmar Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST George Tichinel					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzy Harmon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lena Durst Rt#1 Elk Garden, W.Va						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary stoppage</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of colon with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION Fall, 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/4, 1981, to 8/5, 1981, that (I) (we) last saw the deceased alive on 8/5, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Louis Rishel					DEGREE MD		22c. DATE SIGNED 8/7/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Rishel	
22e. ADDRESS Oakland, Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-8-81		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Swanton Garrett MD				
24. FUNERAL DIRECTOR (NAME) David A Burdock					ADDRESS Kitzmiller, MD					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(V.R. 15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		KNOWN ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Phyllis Edna UPHOLD								8 25 1981										652 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	Dec. 14, 1906		74 YRS.						8 25 1981								652 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		USA				Garrett												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Oakland		Garrett Co. Mem. Hospital		Housewife		Home													
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Garrett		Crellin		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #38											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST		FIRST MIDDLE LAST																	
Joseph David Uphold		Mary Ellen McCabe																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		234-58-0256		Robert Shaffer, Oakland, Maryland		21550													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
4149		Coronary artery disease		Arteriosclerosis, generalized		Years													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Fractured right hip; Old CVA.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
8-24-81		Open reduction right hip with Austin-Moore Prosthesis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
11 xx 8-20-81		11 xx 8-20-81		Fell out of chair.															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION															
Nursing Home		Nursing Home		Dennett Road Manor Nursing Home															
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE															
James H. Feaster, Jr., M. D.		DEPUTY		8-25-81															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
James H. Feaster, Jr., M. D.		107 S. 2nd. St., Oakland, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
burial		8/28/81		Terra Alta Cemetery		Terra Alta, Preston, West Va.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Bradley A. Stewart		Oakland, Maryland		21550		SEP 2 1981													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, if any, is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 4 4 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Clarence Raymond Warnick		MONTH DAY YEAR 8 21 81	
3. SEX		2b. HOUR	
Male		A.M. M	
4. RACE		5. DATE OF BIRTH	
White		MONTH DAY YEAR 5 8 1905	
6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
76 Yrs.		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH	
W.Va.		Garrett MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Oakland		Garrett Co. Memorial Hosp.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Retired		Coal Miner	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	
13a. STATE COUNTY CITY OR TOWN W. Va. Mineral Elk Garden		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Gilbert Warnick		FIRST MIDDLE LAST Emma Sullivan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		236-03-3881	
17. INFORMANT		ADDRESS	
Margaret Warnick		Elk Garden, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>		hrs	
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute MI</u>		hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD</u>	
		yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
Dr. Jared Zelman, M.D.		8/24/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Dr. Jared Zelman, M.D.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		8 24 81	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Mt. Storm		Mt. Storm Grant W.Va.	
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR	
David A. Burbeck Kitzmiller, Md.		AUG 31 1981	

2



MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))
15M 7/76

1908

RECEIVED

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1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this hospital, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 1 2 1 4 4 7

CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Emma Lena YOUNKIN			2a. DATE OF DEATH MONTH DAY YEAR August 30, 1981		2b. HOUR 9 A.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR August 14, 1886		
6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Garrett County, MD.						
10 CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietician		
12b. KIND OF BUSINESS OR INDUSTRY Hospital		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Ohio		13b. CITY OR TOWN Summit		
13c. CITY OR TOWN Akron		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 876 Copley Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST William C. Cochran		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida C. Fogle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 278-22-2220		17. INFORMANT ADDRESS P.O. Box 186 M. Evelyn Yonkin, Grantsville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CX DUE TO, OR AS A CONSEQUENCE OF (b) ASX DUE TO, OR AS A CONSEQUENCE OF (c) ASX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-31-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Gonzaga, M.D.		22e. ADDRESS Frostburg, Md. 21532				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 1, 1981		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 4 1981 <i>[Signature]</i>				
24. FUNERAL DIRECTOR NAME ADDRESS <i>[Signature]</i> Grantsville, Md.						

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